

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

STATE FILE NUMBER

318 1003 1238 63-049882
FILED DEC 20 1963 XC-8 956 274

| | |
|---------------------|--------------|
| VS 300 Rev. 4/59 | DATE AMENDED |
| 1 | |
| 2 81207 I | |
| 3 | |
| 4 0 | |
| 5 1 | |
| 6 | |
| 7 1 | |
| 8 1 | |
| 9 | |
| 10 | |
| 11 | |
| 12 83-0 | |
| 13 | |
| 83 | |

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

BY AFFIDAVIT OF

| | | | |
|--|---|--|-----------------------------|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI | | c. CITY OR TOWN SHELBYVILLE | |
| Length of stay in 1b 51 DAYS | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VAH, ST. LOUIS, MO. | | d. STREET ADDRESS (If outside, give location) 503 SO. BROADWAY | |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | | 4. DATE OF DEATH | |
| First Middle Last HOMER L. REEDY | | Month Day Year 12/13/63 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 8/27/11 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNEMPLOYED PAINTER | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11a. BIRTHPLACE (City and state or country) KIRKSVILLE, ILLINOIS | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13a. FATHER'S NAME AMOS REEDY | | 13b. MOTHER'S MAIDEN NAME TONA HOPKINS | |
| 14. NAME OF HUSBAND OR WIFE LENA REEDY | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW-II | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT LENA REEDY (WIDOW) SEE #2 | |
| 18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: | | INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) Cerebral Edema | | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | DUE TO (b) Uremia 1681.0 | |
| | | DUE TO (c) Chronic Pyelonephritis and Renal Calculi | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Carcinoma of Urinary Bladder | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | |
| 20c. TIME OF INJURY Hour * Month, Day, Year a.m. p.m. | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION COUNTY STATE | |
| 21. VA. attended the deceased from 12/23/63 to 12/13/63 and last saw him alive on 12/13/63 Death occurred at 3:35 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) Martin Roseenthal M.D. | | 22b. ADDRESS VAH, ST. LOUIS, MO. | |
| 22c. DATE SIGNED 12/13/63 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 12-16-63 | |
| 23c. NAME OF CEMETERY OR CREMATORY Glenwood | | 23d. LOCATION (City, town, or county) (State) Shelbyville, Ill. | |
| 24. FUNERAL DIRECTOR Delmar Lockhart | | 25. DATE RECD. BY LOCAL REG. DEC 14 1963 | |
| 26. REGISTRAR'S SIGNATURE Earl Smith, M.D. | | | |

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by Not Embalmed, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed John J. Kessler III

Licensed Embalmer No. 5039

P. O. Address E. St. Louis, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting:

If this body is not embalmed, fact should be so stated above.